State of Utah

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Lieutenant Governor

Department of Human Services

TRACY S. GRUBER
Interim Executive Director

Division of Substance Abuse and Mental Health
DOUG THOMAS
Director

January 28, 2021

Craig Buttars
Cache County Executive
199 North Main
Logan, UT 84321

Dear Mr. Buttars:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of Bear River Health Department and the final report is enclosed. The scope of the review included fiscal management, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard at 385-310-5118.

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

Doug Thomas (Feb 1, 2021 12:44 MST)

Doug Thomas
Division Director

Enclosure
cc: Jeff Scott, Box Elder County Commission
Bill Cox, Rich County Commission
Lloyd Berentzen, Director, Bear River Health Department
Brock Alder, Director, Bear River Substance Abuse

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

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SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

Bear River Health Department
Local Substance Abuse Authority

Local Authority Contract #160048

Review Date: November 17, 2020

Final Report

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Bear River Health Department (also referred to in this report as BRHD or the County) on November 17, 2020. The focus of the review was on governance and oversight, fiscal management, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	7
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	9-10
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	3	11-12
	Deficiency	None	

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review remotely with Bear River Health Department (BRHD) due to Covid-19 restrictions. The Governance and Fiscal Oversight section of the review was conducted on November 17, 2020 by Chad Carter Auditor IV and completed by Kelly Ovard Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Meeting minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and County.

As part of the review, BRHD sent several files to Chad Carter to demonstrate their allocation plan and to justify their billed amounts. The allocation plan is clearly defined and shows how administrative and operational costs are equitably distributed across all cost centers and that the billing costs for services are consistently used throughout the system.

There is a current and valid contract in place between the Division and the Local Authority. BRHD met its obligation of matching a required percentage of State funding.

Bear River Health Department met its obligation to receive a single audit as a component unit of Cache County's single audit. The CPA firm Jones & Simkins P.C. performed the audit on the County for the year ending December 31, 2019. The Independent Auditors' Report dated June 25, 2020 expressed an unmodified opinion. There was one grant deficiency reported in the audit which is addressed in this audit as a deficiency as it involved the Crime Victims grant program.

Jones & Simkins P.C. also performed a specific audit on the financial statements of Bear River Health Department as a component unit of Cache County for the year ending December 31st, 2019. In the Independent Auditors' Report dated May 8, 2020 no deficiencies or material misstatements were reported.

Follow-up from Fiscal Year 2020 Audit:

FY20 Minor Non-compliance Issues:

1) *Personnel Files:* In the review of personnel files, it was found that three clinical employees had BCI background checks that were expired and had not yet been renewed

There were no BCI findings for FY21. This issue has been resolved.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:
None

FY21 Significant Non-compliance Issues:
None

FY21 Minor Non-compliance Issues:
None

FY21 Deficiencies:

1) Finding 2019-001 Information on the Federal Program:
CFDA 16.575 – Crime Victim Assistance, U.S. Department of Justice, passed through the State Office of the Attorney General. Compliance Requirements: Activities Allowed or Unallowed, Allowable Costs and Cost Principles, Cash Management, Procurement, and Reporting.

Type of Finding:
Significant deficiency in internal control over compliance.
Condition: **The County did not strictly enforce its grant management policies related to purchase approval and submission of reimbursement requests resulting in several unallowable purchases being submitted for reimbursement. Cause: Grant management policies and procedures, including monitoring of individual grant program directors, were not strictly enforced.**

Effect or Potential Effect: Activities or costs that are not allowed or allowable were paid and submitted for reimbursement. Questioned Costs: None. All unallowable costs and amounts submitted for reimbursement were subsequently identified and reported to the State agency and repaid.

Center's Response and Corrective Action Plan:

Action Plan: BRHD Counseling Division's policy regarding expenditures, purchases, and reimbursements has been expanded to require full BRHD executive review and authorization on all purchases, regardless of cost. Previous policy did not require authorization beyond Division management for items under $500.

Timeline for compliance: Effective immediately.

Person Responsible for action plan: Brock Alder, L.C.S.W., Counseling Division Director
DSAMH Tracking by: Kelly Ovard

CFY21 Recommendations:

1) The BRHD emergency plan was reviewed by Robert Snarr, Program Administrator as part of the site visit. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that FCCBH review these suggestions and update their emergency plan accordingly. ***The Emergency Plan (Attachment A) has 4 items in non-compliance and 3 items in partial compliance. Please update the Emergency Plan to bring these 7 items into compliance.***

FY21 Division Comments:

None

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Bear River Health Department on November 17th, 2020. The review focused on the requirements found in

State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2020 Audit

FY20 Deficiencies:

1) The number of EASY Compliance Checks decreased from 206 in FY18 to 185 in FY19, which does not meet Division Directives. Local Authorities are required to increase the number of EASY Compliance Checks by at least one EASY Check each year.

The number of EASY Compliance Checks decreased from 185 to 140 from the FY19 to FY20, which does not meet Division Directives. Local Authorities are required to increase the number of EASY Compliance Checks by at least one EASY Check each year

This issue has not been resolved, which will be addressed in Deficiency #1 below.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:
None

FY21 Significant Non-compliance Issues:
None

FY21 Minor Non-compliance Issues:
None

FY21 Deficiencies:

1) The number of EASY Compliance Checks decreased from 185 to 140 from the FY19 to FY20, which does not meet Division Directives. Local Authorities are required to increase the number of EASY Compliance Checks by at least one EASY Check each year.

Center's Response and Corrective Action Plan:

Action Plan: Coordinate with Law Enforcement to conduct at least 3 (and at most 4) alcohol compliance checks in each off-premise alcohol retailer establishment in the Bear River Health District by June 30, 2021.

Timeline for compliance: Quarterly checks during FY20201. Completed by June 30, 2021

Person Responsible for action plan: Charlie Seifert

DSAMH tracking by: Becky King

FY21 Recommendations:

1) **COVID-19 Pandemic** - BRHD has made adjustments to their community events and classes due to the COVID-19 Pandemic. They have been holding their Prime for Life (PRI) and other classes virtually, which has worked well for their community. It is recommended that BRHD continue to find ways of meeting community needs through virtual and COVID safe options.

2) **Scorecard:** The 2020 Prevention Scorecard identifies that none of the 10 communities identified in the BRHD geographic catchment area have completed a community readiness assessment. DSAMH recommends that BRHD work with local communities to complete this process. DSAMH is available to provide technical assistance if needed.

FY21 Division Comments:

1) **Community Partnerships:** BRHD has strengthened community partnerships with businesses, legislators, law enforcement, Utah State University, agencies and treatment Centers. This has been accomplished through Coalition work, Parents Empowered incentives for community partners, Opioid prescription Take Back events and Student Health and Risk Prevention (SHARP) presentations provided to the City Council. Parents Empowered campaigns included events at the ice rink, aquatic center, bowling alley and Zootah.

2) **Risk and Protective Factors:** BRHD has implemented evidence-based practices programs based on the following risk and protective factors identified for their community: (1) Low Commitment to School (2) Attitudes favorable toward anti-social behavior (3) Prosocial Involvement (4) Rewards for Prosocial involvement.

3) **Fidelity Measures:** BRHD is using the following evaluation tools to ensure fidelity in their evidence-based programs: Monthly self-evaluations, pre and post tests, identifying the number of people reached through media messages and maintaining compliance logs for Eliminating Alcohol Sales to Youth (EASY) checks.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the Substance Use Disorders Treatment review for Bear River Health Department on November 17th, 2020. The review focused on compliance with State and Federal law, Substance Abuse Treatment (SAPT) Block Grant regulations, and adherence to DSAMH Directives and contract requirements. The review consisted of an interview with program staff, a review of clinical records and an evaluation of agency policy and procedures. In addition, performance and client satisfaction was measured using the Utah Substance Abuse Treatment Outcomes Measures Scorecard and Consumer Satisfaction Survey Data.

Follow-up from Fiscal Year 2020 Audit

None

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance issues:

None

FY21 Significant Non-compliance issues:

None

FY21 Minor Non-compliance issues:

1) **Decreased Criminal Justice Involvement** moved from 58.2% to 17.5% from the FY19 to FY20 respectively, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

Action Plan: When a client is referred due to CJS involvement, we will include the number of arrests related to the referral at intake in TEDS. This will more accurately reflect the difference between intake and discharge.

Timeline for compliance: Began immediately after site review interviews.

Person Responsible for action plan: Jaylene McNeely, Intake Coordinator

DSAMH tracking by: Becky King

2) **Youth Satisfaction Surveys** shows that 6.3% of surveys were collected, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

Action Plan: This year, we have students that have continued their internships even through Covid-19. They are tasked with contacting youth to complete surveys. Along with this, staff involved with youth services will continue to complete and/or follow up to ensure all youth participate.

Timeline for compliance: January 1, 2021 through deadline for MHSIP surveys.

Person Responsible for action plan: Students and student supervisors.

DSAMH tracking by: Becky King

3) **Youth Satisfaction (Family) Surveys** shows that 0% of surveys were collected, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

Action Plan: As with youth surveys, this year we have students available to assist in conducting family surveys. When family members attend sessions, staff will follow-up to ensure they have the opportunity to participate.

Timeline for compliance: January 1, 2021 through end of MHSIP surveys.

Person Responsible for action plan: Students and student supervisors.

SAMH tracking by: Becky King

FY21 Deficiencies:

None

FY21 Recommendations:

1) **Medicaid** - BRHD has increased enrollment with Medicaid for clients, which has allowed BRHD to provide more services this year. It is recommended that BRHD continue to enroll clients in Medicaid and find other funding avenues to continue providing cost effective services for individuals and families in their program.

FY21 Division Comments:

1) **Staff Turnover** - BRHD has experienced staff turnover over the past year, which has been difficult for their team. However, they have continued to provide services despite a reduction in their staff. BRHD is dedicated to providing quality services to the community.

2) **COVID-19 Pandemic** - When the COVID-19 Pandemic started, BRHD provided virtual groups for a while, then brought back clients into their office, which is working well. Clients and staff are required to take temperatures and wear masks to participate in services on site.

3) **Medication Assisted Treatment (MAT) -** BRHD is providing MAT for their community, including Suboxone and Vivitrol. They have partnered with the Intermountain Day Spring Opioid Treatment Provider Program, which provides various forms of MAT, including Methadone. However, to date, BRHD has not referred clients for methadone. DSAMH recommends educating staff and clients on the benefits of methadone treatment and expanding this partnership.

4) BRHD started a **Vivitrol Program** in the jail, which is on hold due to COVID. However, they are planning to restart this program when they are able to get it started again.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within **10 working days** of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within **15 working days** of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to require a formal action plan. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Bear River Health Department and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Kelly Ovard at 385-310-5118

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard Kelly Jay Ovard Date 02/01/2021
Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 02/01/2021
Administrative Services Director

Brent Kelsey Brent Kelsey Date 02/01/2021
Assistant Director Substance Abuse

Doug Thomas D. P. Thomas Doug Thomas (Feb 1, 2021 12:44 MST) Date 02/01/2021
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY21

Name of Local Authority: **Bear River Health Department**

Date: **November 17, 2020**

Reviewed by: **Robert H. Snarr, MPA, LCMHC**
Geri Jardine

Compliance Ratings

Y = Yes, the Contractor is in compliance with the requirements.
P = Partial, the Contractor is in partial compliance with requirements; comments provided as a suggestion to bring into compliance.
N = No, the Contractor is not in compliance with the requirements.

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)			X	Need signature page, approval of plan and confirmation of its official status
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)		X		Need to include record of revisions dates
Record of changes (indicating when changes have been made and to which components of the plan)			X	Need place to identify changes to the plan, made by whom, and date of change
Record of distribution (individual internal and external recipients identified by organization and title)			X	Need distribution record
Table of contents	X			
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan		X		Need to identify the methods for communicating changes and how staff are trained.
Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.				
List of essential functions and essential staff positions	X			
Identify continuity of leadership and orders of succession	X			

Identify leadership for incident response	X			
List alternative facilities (including the address of and directions/mileage to each)		X		Need to identify alternative facilities to be used, if needed
Address recovery and maintenance of client records			X	Need to address the recovery and maintenance of client records
Communication procedures with staff, clients' families, the State and community	X			
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Planning Step				
Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)	X			
The planning team has identified requirements for disaster planning for Residential/Housing services including: ● Engineering maintenance ● Housekeeping services ● Food services ● Pharmacy services ● Transportation services ● Evacuation procedures ● Isolation/Quarantine procedures ● Maintenance of required staffing ratios ● Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic	X			Need to specify how these functions will be provided

DSAMH is happy to provide technical assistance.

DSAMH BRHD FY21 Final Report

Final Audit Report 2021-02-01

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